U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 April 2005

CASE NO.: 2003-BLA-05056

In the Matter of

CHARLES W. HUDSON
Claimant

v.

PEABODY COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

JAMES M. PHEMISTER, Esquire
GREER D. SMITH, Student Caseworker
For Claimant

PAUL E. FRAMPTON, Esquire
For Employer

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS ON SUBSEQUENT CLAIM

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901–945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On October 8, 2002, this case was referred to the Office of Administrative Law Judges ("OALJ") for a formal hearing. DX 32.[1] The case was assigned to me on April 12, 2004. The hearing was held before me in Charleston, West Virginia on August 31, 2004, at which time the parties had full opportunity to present evidence and argument. This decision is based on an analysis of the record, the arguments of the parties, and the applicable law. At the hearing, Claimant's Exhibits 1–3, 6–8[2] and Employer's Exhibits 2–3 were identified and received into the record. Hearing Transcript at 38, 45, 48, 53–54, 56, 59, 65–67. CX 4, comprised of Dr. Alexander's rebuttal regarding CT scans dated 5/29/01; 7/11/01; 10/15/01; and 2/18/02; and CX 5, comprised of Dr. Cohen's August 3, 2004 report, were generally discussed at the hearing but were not officially admitted. Hearing Transcript at 28–30, 65. They are now identified and received into the record. EX 1, comprised of Dr. Fino's March 28, 2003 report, and DX 26, comprised of Dr. Wheeler's interpretations of CT scans dated 11/24/00; 2/14/01; 3/28/01; and 5/29/01, were both excluded at the hearing. Hearing Transcript at 38, 53. DX 21 was admitted only in part as Dr. Zaldivar's interpretation of the May 16, 2001 chest x-ray film is excluded from consideration. Hearing Transcript at 58. Director's Exhibits 1–20, 22–25, and 27–34 are now identified and received into evidence. Finally, CX 9 and EX 4–7 were received post-hearing and pursuant to the discussions at the hearing, these exhibits are received into evidence. Hearing Transcript at 29, 37–38, 45, 59–60. The record is now closed.

Claimant and Employer submitted briefs on January 17, 2005, respectively.

ISSUES

Before the undersigned is a duplicate claim. The following issues are presented for adjudication:

1. Claimant's post-1969 coal mine employment;

2. Whether Peabody Coal Company is the responsible operator in this case;

3. The length of Claimant's coal mine employment;

4. The number of Claimant's dependents for purposes of augmentation of benefits;

5. Whether Claimant has pneumoconiosis;

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[1]In this Decision and Order, "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; and "Hearing Transcript" refers to the transcript from the August 31, 2004 hearing.

[2]There was some discussion at the hearing that Dr. Alexander's rebuttal report of July 30, 2004 would be amended and submitted post-hearing. Claimant has not submitted any revision to Dr. Alexander's CT rebuttal evidence, however. To the extent that this report addresses Dr. Wheeler's opinion regarding some CT scans, and where those particular opinions were excluded at the hearing, I will disregard them. I will address only that content that pertains to Dr. Alexander's general opinion about these CT scans.

6. Whether Claimant's pneumoconiosis arose out of coal mine employment;

7. Whether Claimant is totally disabled;

8. Whether Claimant's total disability is due to pneumoconiosis; and

9. Whether Claimant has established a change in conditions pursuant to § 725.309.

DX 32; Hearing Transcript at 67–68.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Claimant filed an initial claim for benefits on September 23, 1970. DX 1. The District Director denied the claim on July 29, 1981. DX 1. At that time, the Director found that Claimant had established no elements of entitlement.

Claimant filed the instant claim for benefits on January 24, 2001. DX 3. The District Director denied benefits on April 12, 2002. DX 27. The District Director found that Claimant had established the presence of pneumoconiosis arising from coal mine employment, but that he had not established a total respiratory disability. DX 27. Claimant requested a hearing on April 24, 2002. DX 28. Employer contested all elements of eligibility for benefits under the Act.

B. Factual Background

Claimant was born on January 4, 1925, and is currently 80 years old. He has an 8th grade education. DX 3. He married Maxine Harmon on June 5, 1947, and remains married to her. Hearing Transcript at 70; DX 12.

Claimant testified that he is short of breath and has to use an inhaler at night or go outside to "get my breath." He also testified that he can no longer participate in activities that he once did, such as hunting or mowing his own lawn. Hearing Transcript at 76.

C. Number of Claimant's Dependents

Based on Claimant's testimony, I find that his wife, Maxine, is his only dependent for purposes of augmentation of benefits under the Act.

D. Responsible Operator

Peabody Coal Company contests that it is the responsible operator in this case. Social Security Records establish that Claimant's last coal mine employment for a period of at least one year (i.e., 1990) was with Peabody Coal Company. Claimant testified that he had not worked in coal mine employment after 1990 when he retired. There is no other evidence to suggest that he worked in any mine after 1990. The District Director in this case named Peabody Coal

Company as the responsible operator. DX 27. Pursuant to § 725.465(b), "the administrative law judge shall not dismiss the operator designated as the responsible operator by the district director, except upon the motion or written agreement of the Director." The Director has filed no such motion or written agreement.

Based on the foregoing, I find that Peabody Coal Company is the responsible operator in this case.

E. Coal Mine Employment

1. Length of Coal Mine Employment

In its Proposed Decision and Order of April 12, 2002, Director found that Claimant had established 45 years of coal mine employment. DX 27. At the hearing, the parties stipulated that Claimant had established at least 30 years of coal mine employment. Hearing Transcript at 68–69.

Claimant testified that he began working in the coal mines when he was 17 years old. He worked for about six months before he was drafted into the service. Hearing Transcript at 70. Upon his return he worked underground in the mines operating loading machines, cutting machines and continuous miners. The latter was a machine that "dug the coal from the seam and loaded it into shuttle cars." He testified that he worked underground for about 40 years, and then above ground for an additional six years. When working above ground, he operated a thermo-dryer, a machine that dried the coal. Claimant was responsible for checking the furnace and putting out any fires. He also performed other tasks, including "car dropping," which involved loading cars with coal, three at a time, and pulling the cars about ¼ of a mile. Hearing Transcript at 71–76.

In order to calculate the number of years of Claimant's coal mine employment, I refer to § 725.101(a)(32) which provides that a "year" means: "a period of one calendar year (365 days, or 366 days if one of the days is February 29), or partial periods totaling one year, during which the miner worked in or around a coal mine or mines for at least 125 'working days.'" This section also provides that:

> If the evidence establishes that the miner worked in or around coal mines at least 125 working days during a calendar year or partial periods totaling one year, then the miner has worked one year in coal mine employment for all purposes under the Act. If a miner worked fewer than 125 working days in a year, he or she has worked a fractional year based on the ratio of actual number of days worked to 125.

§ 725.101(a)(32)(i).

This section also provides that "to the extent the evidence permits, the beginning and ending dates of coal mine employment shall be ascertained." § 725.101(a)(32)(ii). This section further provides:

> If the evidence is insufficient to establish the beginning and ending dates of the miner's coal mine employment, or the miner's employment lasted less than a calendar year, than the adjudication officer may use the following formula: divide the yearly income from work as a miner by the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics (BLS). A copy of the BLS table shall be made part of the record if the adjudication officer uses this method to establish the length of the miner's work history.

§ 725.101(a)(32)(iii).

The Bureau of Labor Statistics does not actually provide the necessary data described in the regulations, therefore, I rely on the BLBA Procedure Manual 2-700.11a and 2-700.14a to determine Claimant's coal mine employment. The table provided in this section indicates the average yearly and average daily earnings for coal miners. I compare this to Claimant's history of earnings from the Social Security records, various employer/coal company records, and Claimant's application, to calculate the length of Claimant's coal mine employment.[3] DX 4–10. The application of the above-described formula to the present facts is as follows:

Year	Company	Daily average earnings ÷ (BLBA)	Total Days/Years
1942	Anchor Coal Co.	$624.91 ÷ 5.64	111 days
1943	Anchor Coal Co.	$483.46 ÷ 5.19	93 days
1945	Anchor Coal Co.	$285.61 ÷ 7.01	41 days
1946	Anchor Coal Co.	$2,897.34 (*Exceeds yearly average*)	1 year
1947	Anchor Coal Co.	$3,000.00	
1947	Glogora Coal Co.	$315.45	
1947	Kessler Coals Inc.	No earnings reported	
		Subtotal $3,315.45 (*Exceeds yearly average*)	1 year
1948	Anchor Coal Co.	$41.66	
1948	Glogora Coal Co.	$2,894.30	
1948	Kessler Coals Inc.	No earnings reported	
		Subtotal $2,935.96 (*Exceeds yearly average*)	1 year
1949	Glogora Coal Co.	$2,240.08	
1949	Kessler Coals Inc.	No earnings reported	

[3] A copy of the BLBA table is now made part of the record as "ALJ-1" pursuant to § 725.101(a)(32)(iii).

		Subtotal $2,240.08 (*Exceeds yearly average*)	1 year
1950	Anchor Coal Co.	$816.43	
1950	Glogora Coal Co.	$50.00	
		Subtotal $866.43 ÷ 12.43	70 days
1951	Anchor Coal Co.	$3,600.00 (Exceeds yearly average)	1 year
1952	Anchor Coal Co.	$3,600.00 (Exceeds yearly average)	1 year
1953	Anchor Coal Co.	$3,600.00 (Exceeds yearly average)	1 year
1954	Anchor Coal Co.	$3,600.00 (Exceeds yearly average)	1 year
1955	Anchor Coal Co.	$4,200.00 (Exceeds yearly average)	1 year
1956	Anchor Coal Co.	$957.78	
1956	Glogora Coal Co.	$320.55	
1956	North American Coal	$4,076.74	
		Subtotal $5,355.07 (*Exceeds yearly average*)	1 year
1957	Glogora Coal Co.	$3,430.18	
1957	Truax Traer Coal Co.	$1,784.00	
1957	Bethlehem Mines Corp.	No earnings reported	
		Subtotal $5,214.18 (*Exceeds yearly average*)	1 year
1958	Glogora Coal Co.	$30.00	
1958	Truax Traer Coal Co.	$4,200.00	
1958	Bethlehem Mines Corp.	No earnings reported	
		Subtotal $4,230.00 (*Exceeds yearly average*)	1 year
1959	Bethlehem Mines Corp.	No earnings reported	
1959	Truax Traer Coal Co.	$4,603.19	
1959	Oglebay Norton Co.	$1,192.26	
		Subtotal $5,795.45 (*Exceeds yearly average*)	1 year
1960	Bethlehem Mines Corp.	No earnings reported	
1960	Oglebay Norton Co.	$4,800.00	
		Subtotal $4,800.00 (*Exceeds yearly average*)	1 year
1961	Bethlehem Mines Corp.	No earnings reported	
1961	Oglebay Norton Co.	$4,800.00	
		Subtotal $4,800.00 (*Exceeds yearly average*)	1 year
1962	Carbon Fuel Co.	$475.90	
1962	Bethlehem Mines Corp.	No earnings reported	
1962	Oglebay Norton Co.	$4,800.00	
		Subtotal $5,275.90 (*Exceeds yearly average*)	1 year
1963	Carbon Fuel Co.	$346.47	

1963	Bethlehem Mines Corp.	No earnings reported	
1963	Oglebay Norton Co.	$4,800.00	
		Subtotal $5,146.47 (*Exceeds yearly average*)	1 year
1964	Bethlehem Mines Corp.	No earnings reported	
1964	Oglebay Norton Co.	$4,800.00	
		Subtotal $4,800.00 (*Exceeds yearly average*)	1 year
1965	Peabody Armco Steel Corp.	$2,196.35 (*Exceeds yearly average*)	
	Oglebay Norton Co.	$4,800.00	
	Bethlehem Mines Corp.	No earnings reported	
		Subtotal $6,996.35 (*Exceeds yearly average*)	1 year
1966—1989			
	Peabody Armco Steel Corp.	*All earnings for these years exceed the yearly average*	24 years
1990	Peabody Armco Steel Corp.	$6,899.68 ÷ 133.68	52 days
TOTAL			**45.93 yrs**

Based on Social Security earnings records, coal mine employer records, and Claimant's own testimony, I find that he has established 45.93 years in coal mine employment.

2. Post-1969 Coal Mine Employment

The record establishes that Claimant worked as a coal miner for Peabody Coal Co. until 1990. I find, therefore, that Claimant was employed as a coal miner after December 31, 1969.

F. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. 20 C.F.R. § 718.2. In order to establish entitlement to benefits under § 718, Claimant must prove that (1) he has a history of coal mine employment; (2) that he has pneumoconiosis; (3) that pneumoconiosis arose out of his coal mine employment; (4) that he is totally disabled; and (5) that his total disability is due to pneumoconiosis. Claimant has the burden of establishing each element of entitlement by a preponderance of the evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

In addition, Claimant must fulfill the requirements of the subsequent claim provisions of § 725.309(d), which apply to any claim for benefits that is filed more than one year after the denial of a previous claim. Specifically, amended regulation § 725.309(d) provides as follows:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part…the later claim shall be considered a subsequent claim for benefits. A subsequent claim…shall be

> denied unless the claimant demonstrates that one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate.

§ 725.309(d). This section also provides that "the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based." § 725.309(d)(2). In the instant case, Claimant's most recent claim was finally denied on July 29, 1981 because he was unable to establish any element of entitlement. DX 1. Therefore, in order to qualify for benefits, Claimant must establish that there has been a change in his condition since this denial. 20 C.F.R. § 725.309(d)(2). The regulations also provide that when an element of entitlement relates to a claimant's physical condition, he must establish that element by way of new evidence. § 725.309(d)(3). If a claimant is able to establish that element of entitlement, generally speaking, no prior findings shall be binding in the adjudication of the subsequent claim. § 725.309(d)(4).

The amended regulations essentially reflect the position of the United States Court of Appeals for the Fourth Circuit regarding duplicate claims.[4] In *Lisa Lee Mines v. Director, OWCP,* 57 F.3d 402 (4th Cir. 1995), the Fourth Circuit adopted the view of the United States Court of Appeals for the Sixth Circuit. In *Sharondale Corp. v. Ross,* 42 F.3d 993 (6th Cir. 1994) the Sixth Circuit held:

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the ALJ must consider whether all of the record evidence including that submitted with previous claims, supports a finding of entitlement of benefits.

Sharondale, 42 F.3d at 997–998.

SUMMARY OF MEDICAL EVIDENCE

Chest X-rays

The record contains the following newly submitted chest x-ray interpretations:[5]

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[4]This case arises in the United States Court of Appeals for the Fourth Circuit because Claimant's coal mine employment took place in West Virginia.

[5]A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology or diagnostic

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASSIFICATION
07/09/80	08/02/04	CX 6	Alexander	BCR, B	2/3
07/09/80	09/13/04	EX 5	Wheeler	BCR, B	Unreadable film
03/27/01	03/27/01	DX 14	Ranavaya	B	2/1
03/27/01	09/21/02	EX 5	Wheeler	BCR, B	0/1
03/27/01	10/20/03	CX 1,3	Alexander	BCR, B	3/2
05/16/01	06/20/01	EX 5	Wheeler	BCR, B	1/0
05/16/01	10/28/03	CX 2,3	Alexander	BCR, B	3/2 (Type "A" opacities)
02/07/03	08/02/04	CX 7,3	Alexander	BCR, B	3/2 (Type "A" opacities)
02/07/03	09/13/04	EX 5	Wheeler	BCR, B	Negative
07/14/04	08/05/04	EX 5	Wheeler	BCR, B	Negative
07/14/04	10/09/04	CX 9,3	Alexander	BCR, B	3/2 (Type "A" opacities)

The following chest x-ray interpretations were submitted in association with Claimant's first claim:

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASSIFICATION
01/19/71	12/13/72	DX 1	Donner	—	1/0
03/19/71	03/19/71	DX 1	Allen	—	3/3
04/10/73	04/10/73	DX 1	Kugel	—	1/2

There is also a previously submitted x-ray report dated September 29, 1978 that contains the following comment: "There is nodular fibrosis through both lung fields consistent with pneumoconiosis if there is a suitable occupational history." DX 1. This is signed by Dr. Ahmed.

Pulmonary Function Studies

The record contains the following newly submitted pulmonary function studies:

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	MVV	FVC	FEV_1/ FVC	EFFORT	QUALIFIES
03/27/01	DX 14	Ranavaya	76	1.93 2.10*	59 56*	2.44 2.81*	79% 74%*	Good Good*	No No*

roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii).

05/16/01	DX 21	Zaldivar	76	2.14 2.30*	97 115*	3.07 3.19*	70% 72%*	— —*	No No*
07/14/04	EX 4	Zaldivar	79	1.90 1.87*	— —*	2.78 2.69*	69% 69%*	— —*	No No*

*post-bronchodilator

The following pulmonary function study was submitted in association with Claimant's first claim:

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	MVV	FVC	FEV_1/ FVC	EFFORT	QUALIFIES
03/24/79	DX 1	Zaldivar	54	3.07	102	4.00	77%	—	No

Arterial Blood Gas Studies

The record contains the following newly submitted arterial blood gas studies:

DATE	EX. NO.	PHYSICIAN	pCO_2	pO_2	QUALIFIES
03/27/01	DX 14	Ranavaya	33 33*	98 83*	No No*
05/16/01	DX 21	Zaldivar	32 34*	85 76*	No No*
07/14/04	EX 4	Zaldivar	33	83	No

*post-exercise

The following arterial blood gas study was submitted in association with Claimant's first claim:

DATE	EX. NO.	PHYSICIAN	pCO_2	pO_2	QUALIFIES
03/24/79	DX 1	Zaldivar	26 28*	86 82*	No No*

*post-exercise

Physician Opinions

The current record contains the following physician opinions:

Dr. Mohammed I. Ranavaya (Board-certified in Preventive Medicine and Occupational Medicine)[6] examined Claimant on behalf of the Department of Labor on March 27, 2001. DX 14. Dr. Ranavaya assumed a coal mine employment history of 47 years which was substantially

[6]American Board of Medical Specialties (visited April 12, 2005) <http://www.abms.org>.

performed underground. Dr. Ranavaya reported that Claimant had smoked 1.5 packs of cigarettes a day from 1942 until 1964. Claimant's subjective complaints included sputum production, wheezing, dyspnea, cough, hemoptysis, chest pain, orthopnea, and paroxysmal nocturnal dyspnea. Dr. Ranavaya reviewed a chest x-ray, pulmonary function and arterial blood gas studies, and an EKG. Dr. Ranavaya concluded that Claimant had pneumoconiosis based on his coal mine dust exposure and chest x-ray. He concluded that this condition arose out of Claimant's coal mine employment. Dr. Ranavaya diagnosed no pulmonary impairment, nor did he diagnose complicated pneumoconiosis. DX 14.

Dr. Robert A. Cohen (Board-certified in Internal Medicine and Pulmonary Diseases, B-reader) reviewed the medical records in this case. CX 5. He assumed an underground coal mine employment history of more than 45 years, and a smoking history of approximately 20 years. Dr. Cohen recorded Claimant's medical history as well. He observed that Claimant's subjective complaints included cough, sputum production, dyspnea, and wheezing. He noted that pulmonary function studies showed a "mild obstruction and low normal FVC". Dr. Cohen also found evidence of a restrictive impairment. He opined that both the CT scan evidence and the chest x-ray evidence showed evidence of pneumoconiosis. Dr. Cohen wrote that "[a]t most we can say that he had latent tuberculosis infection which was treated with prophylaxis. This would not cause any changes on CXR or the type of scarring seen in [Claimant]'s case." Dr. Cohen concluded as follows:

> It is my opinion that the sum of the medical evidence in conjunction with this patient's work history indicates that this patient's more than 45 years of heavy coal mine dust exposure and his remote history of 20 pack years of tobacco smoke exposure was significantly contributory to the development of his obstructive and restrictive lung disease and gas exchange abnormalities with exercise. This resulting respiratory impairment was disabling for his last coal mine job.

CX 5. Specifically on the issue of disability, Dr. Cohen wrote: "[Claimant] could not tolerate the dusty atmosphere of a coal mine nor perform the physical labor required by his last coal-mining job because of [his] pulmonary impairment." CX 5.

In a brief letter dated November 11, 2001, Claimant's treating physician, Dr. Alfred K. Pfister wrote as follows:

> [Claimant] has had hemoptysis several times and several serial CT scans which showed nodules on his lungs.
>
> He is disabled due to occupational pneumoconiosis.

DX 24.

On May 16, 2001, Dr. George L. Zaldivar (Board-certified in Internal Medicine and Pulmonary Diseases, B-reader) examined Claimant. DX 21. Dr. Zaldivar's report included his

examination findings and review of medical records. The doctor assumed a coal mine employment history of 47 years and noted that Claimant had smoked one pack of cigarettes a day for about twenty years. He reviewed a pulmonary function study that he characterized as showing a "mild restriction in lung volume" and a "mild diffusion impairment with normal DL/VA." DX 21. He noted a "mild drop" in Claimant's pO2 during exercise. He wrote as follows:

1. [Claimant] has radiographic evidence of simple pneumoconiosis.
2. He has a minimal pulmonary impairment due to the pneumoconiosis. This impairment is reflected in the mild reduction of the total lung capacity and the diffusing capacity. This minimal abnormality has not resulted in any clinical impairment. From the pulmonary standpoint, according to all the tests, which I performed, [Claimant] is capable of performing his usual coal mining work, or work requiring similar exertion.
3. The reason…that he is short of breath is that he is deconditioned. This is brought about by advanced age and inactivity.

DX 21.

At his examination of Claimant on July 14, 2004, Dr. Zaldivar reported that Claimant's shortness of breath had lasted for about 15 or 20 years. EX 4. The doctor recorded Claimant's medical history and reviewed an arterial blood gas and a pulmonary function study, and the concluded that Claimant had pneumoconiosis and a "mild restrictive impairment" resulting from that condition. Dr. Zaldivar found no gas exchange abnormality and he stated that from a pulmonary standpoint, Claimant "is capable of performing his last coal mining work." EX 4.

Dr. Zaldivar testified at deposition on August 30, 2004, and described Claimant's medical history and the significance of Claimant's prophylactic treatment for tuberculosis. EX 2, p.11–17. Dr. Zaldivar also stated that the CT scan taken in July 2004 showed nodules "scattered throughout the lungs that are compatible with simple pneumoconiosis," though he found that none were larger than one centimeter and could be "compatible with an infection as well". Dr. Zaldivar also found the presence of emphysema. EX 2, p.18. The doctor's review of the chest x-ray evidence disclosed no evidence of complicated pneumoconiosis. EX 2, p.20. Dr. Zaldivar also testified that Claimant's pulmonary function studies from 2001 were "entirely normal," although the doctor admitted that his total lung capacity showed a mild restriction attributable to his past cigarette smoking. EX 2, p.21. Dr. Zaldivar also noted a "mild decrement" in the diffusing capacity of the lungs that "could be the result of—coal workers' pneumoconiosis." EX 2, p.22. Dr. Zaldivar reported that the most recent pulmonary function study taken in 2004 essentially produced the same findings. He opined that neither test showed a pulmonary impairment, and that neither test showed an obstructive defect. EX 2, p.24. Claimant's blood tests were normal as well. EX 2, p.28. On cross-examination, Dr. Zaldivar stated that Claimant had a "diffusion impairment" that was "likely due to pneumoconiosis." EX 2, p.31. He denied that Claimant had a restrictive impairment because "[t]he restriction couldn't be from pneumoconiosis because coalworkers' pneumoconiosis does not cause a restriction." EX 2, p.31.

Dr. Zaldivar had also examined Claimant on March 24, 1979 in association with his first

claim for benefits. DX 1. Dr. Zaldivar noted that Claimant experienced shortness of breath with changes in the weather and when climbing. DX 1. He reported that Claimant had worked in the mines for 34 years and was a "non-smoker." He noted that Claimant's spirometry was "normal." He also reported that Claimant showed a "mild drop in arterial oxygenation with exercise and "abnormal (A-a) gradient during exercise." He assessed a "mildly abnormal ventilatory equivalent." He diagnosed chronic bronchitis and found a "mild pulmonary impairment by exercise." In this report Dr. Zaldivar provided no opinion as to whether or not the chronic bronchitis was due to coal mine dust exposure. DX 1.

Dr. Ben Branscomb was deposed on August 30, 2004. EX 3. He assumed a coal mine employment history of about 45 years, and described Claimant's coal mine work as being performed both underground and above ground "in some very dusty exposures." EX 3, p.13. He assumed a smoking history of as much as a "pack-and-a-half for about 22 years." EX 3, p.14. Dr. Branscomb observed that Claimant had a history of hemoptysis dating back to 1961 possibly due to bronchiectasis, or possibly tuberculosis. EX 3, p.15; 18. He explained that an individual could have "bleeding from old TB cavities when it's [sic] not active," but said that histoplasmosis could manifest similarly. EX 3, p.20. The records indicated that Claimant had been treated with isoniazid, an antibiotic that is considered "effective on the tuberculosis organism." EX 3, p.23. This treatment took place in 2000 and 2001. EX 3, p.27–28. Dr. Branscomb clarified that Claimant appeared to have some residual traces of tuberculosis, not active tuberculosis. EX 3, p.21–25. He summarized that Claimant could have also had histoplasmosis, and that this was even more likely than tuberculosis. EX 3, p.30. He opined that Claimant did not have pneumoconiosis because there were other more likely causes to the changes seen on chest x-rays. EX 3, p.32. He also noted that Claimant's lymph node enlargement was consistent with tuberculosis and histoplasmosis, not pneumoconiosis. EX 3, p.34. He further stated that the "apical cavitation" and "increased scarring" near that area seen on x-ray is "exactly typical for TB and for histoplasmosis." EX 3, p.33. Dr. Branscomb commented that even if Claimant had pneumoconiosis, it was not complicated pneumoconiosis, because the opacities on Claimant's chest C-rays and CT scans are "located in the part of the lung where granulomatous disease ordinarily starts and goes and produces larger lesions." EX 3, p.47–48. Dr. Branscomb also testified that Claimant's pulmonary function testing showed that he had "excellent lung function just the same as the healthy normals from whom the standards were derived." EX 3, p.49. Dr. Branscomb also stated that these tests showed no obstruction, but that the most recent test showed signs of restrictive impairment. He further opined that the testing did not indicate the presence of any coal mine-induced lung disease, and concluded that Claimant was not impaired. EX 3, p.52–54. On cross-examination, he reiterated that even if he assumed that Claimant had pneumoconiosis, it was simple, not complicated. EX 3, p.69–70.

The record also contains a mostly illegible report associated with Claimant's initial filing that indicates that Claimant was found to have pulmonary fibrosis and pneumoconiosis by a state agency. DX 1.

CT Scans

The eight CT scans of record are summarized below.

November 24, 2000 CT Scan

In a report dated July 24, 2001, Dr. William Scott reported that this CT scan showed:

> linear scars and few sub-centimeter nodules in apices, left more than right compatible with tuberculosis of unknown activity, at least partially healed. There are additional scattered densities in the periphery of the mid and lower lungs and a few small linear scars probably of the same etiology.

The doctor wrote that the "pattern of densities" were "not compatible with silicosis/CWP" and that metastases could not be entirely excluded. DX 25.

In a report dated July 30, 2004, Dr. Alexander reviewed this same scan and found opacities that were consistent with Category A complicated coal workers' pneumoconiosis, focal emphysema in the anterior left upper zone, and no pleural abnormalities. CX 8.

February 14, 2001 CT Scan

In his July 24, 2001 report Dr. Scott reviewed this CT scan and found "pulmonary vascular congestion due to CHF and/or fluid overload appearing since exam November 2000." DX 25.

In a report dated July 30, 2004, Dr. Alexander wrote that this CT scan showed evidence of "Category A complicated Coal Worker's Pneumoconiosis." He noted that this scan showed a large opacity in the right upper zone, and areas of emphysema. He found "interstitial markings in the posterior (dependent) lung bases" that "may indicate an acute infectious or inflammatory process or congestive heart failure." He also noted that there were no pleural abnormalities. CX 8.

March 28, 2001 CT Scan

In his July 24, 2001 report Dr. Scott found "pulmonary vascular congestion due to CHF and/or fluid overload since 14 February 2001. Appearance is now unchanged from exam of 24 November 2000." DX 25.

In a report dated July 30, 2004, Dr. Alexander wrote that this CT scan showed evidence of Category A complicated coal worker's pneumoconiosis. He also noted that there was "progression of left upper zone coalescence". He concluded that this scan also showed "further coalescence of small opacities to the point where 6mm and 8mm are now present in the left upper zone." CX 8.

May 29, 2001 CT Scan

Dr. Scott found "no change since exam of 28 March 2001." DX 25.

In a report dated April 7, 2004, Dr. Alexander reviewed this scan and found it positive for complicated pneumoconiosis. CX 4.

July 11, 2001 CT Scan

Dr. Wheeler reported that this CT scan showed no evidence of pneumoconiosis. He also reported that there was "minimal to moderate linear and irregular fibrosis" with "few small nodules and linear scar right apex compatible with healed pneumonia, probably TB." He also found:

> Few small nodules and linear scars in periphery both upper lobes compatible with granulomatous disease unknown activity, at least partly healed. Minimal ill defined interstitial fibrosis or interstitial infiltrate periphery LLL and in posterior periphery RLL possibly autoimmune disease or usual interstitial pneumonitis (UIP). 1.5 cm nodule posterior periphery RLL compatible with granuloma or tumor. Minimal adenopathy in right paratracheal node and node in aortopulmonary angle left hilum compatible with inflammatory disease.

EX 7.

In his April 7, 2004 report, Dr. Alexander reviewed this scan and found it positive for complicated pneumoconiosis. CX 4.

October 15, 2001 CT Scan

Dr. Wheeler reported that this CT scan showed no evidence of pneumoconiosis. Other findings included: "nodular infiltrates increasing in RUL since last CT scan compatible with active TB or histoplasmosis more likely than metatases [sic]. Check clinically because exact diagnosis is needed." EX 7.

In his April 7, 2004 report, Dr. Alexander reviewed this scan and found it positive for complicated coal workers' pneumoconiosis. CX 4.

February 18, 2002 CT Scan

In a report dated October 20, 2003, Dr. Paul Wheeler reported that this CT scan showed no evidence of pneumoconiosis, but showed "nodular infiltrates RUL decreasing since last CT scan compatible with resolving granulomatous disease, most likely TB. No other change." EX 7.

In a report dated April 7, 2004, Dr. Alexander wrote that this CT scan was of the best diagnostic quality and that the findings were "present and stable" with those CT scans that preceded it. CX 4. Dr. Alexander wrote that he saw "bilateral upper zone large opacities consistent with complicated Coal Workers' Pneumoconiosis." CX 4. He wrote that the

"summed diameter of these large opacities is less than 50.0mm, they would constitute category A complicated Coal Workers' Pneumoconiosis." He also saw evidence of focal emphysema.

July 14, 2004 CT Scan

Dr. Scott wrote that this CT scan showed scarring "most likely due to healed infection process," "emphysema," "coronary artery calcification," and "no symmetrical rounded opacities to suggest silicosis/CWP." EX 6.

In his most recent report, Dr. Alexander wrote that, in general, Claimant's CT scans "demonstrate abnormalities that indicate the presence of complicated Coal Worker's Pneumoconiosis." He disagreed that the fibrotic changes in the left upper zone were due to previous infection such as tuberculosis because there were none of the typical findings associated with that process such as lymphadenopathy, calcified lesions, or pleural thickening. CX 8.

Medical Records

Records from the Charleston Area Medical Center reveal that the miner was hospitalized in November 2000, after seeking treatment at the emergency room for expectorating blood. DX 13. He underwent a fiberoptic bronchoscopy, and his final diagnoses included: hemoptysis, coal workers' pneumoconiosis, hypertension, hyperlipidemia, coronary artery disease, glaucoma, and subdural hematoma, stable. DX 13. A CT scan taken during this hospital stay dated November 24, 2000, revealed the following:

> Fibronodular increased interstitial markings throughout the lungs with scarring in the lung apices. The largest pulmonary nodule measuring approximately 6x10mm and is at the periphery of the right upper lobe. There are a few nonspecific lymph nodes within the mediastinum.
>
> There are two hyperdensities which likely reflect cysts. If indicated a follow-up CT in 3 to 6 months would be of value to verify stability of the nodular densities within the lungs.

DX 13. The discharge record stated that Claimant "[u]nquestionably" had pneumoconiosis. DX 13. The bronchoscopy showed as follows: "no malignant cells; reactive changes; blood is present; squamous metaplastic cells present." DX 13.

DISCUSSION OF EVIDENCE

A. Presence of Pneumoconiosis

Section 718.201 defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal,' pneumoconiosis." Section 718.201(a)(1) and (2) defines clinical pneumoconiosis and legal

pneumoconiosis. Section 718.201(3) states that:

> a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (4):

1. X-ray evidence. § 718.202(a)(1).

2. Biopsy or autopsy evidence. § 718.202(a)(2).

3. Regulatory presumptions. § 718.202(a)(3).

   (a) § 718.304—Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

   (b) § 718.305—Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is no other evidence demonstrating the existence of a totally disabling respiratory or pulmonary impairment.

   (c) § 718.306—Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978, and was employed in one or more coal mines prior to June 30, 1971.

4. Physicians' opinions based upon objective medical evidence. § 718.202(a)(4).

The United States Court of the Appeals for the Fourth Circuit has held that in considering whether the presence of pneumoconiosis has been established all evidence must be weighed together. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Chest x-ray evidence § 718.202(a)(1).

Pursuant to § 718.202(a)(1), the existence of pneumoconiosis can be established by chest x-rays conducted and classified in accordance with § 718.102. It is well-established that the interpretation of a chest x-ray by a B-reader may be given additional weight by the fact-finder. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32, 34 (1985); *Martin v. Director, OWCP*, 6

B.L.R. 1-535, 537 (1983); *Sharpless v. Califano*, 585 F.2d 64, 666–67 (4th Cir. 1978). The Board has also held that the interpretation of a chest x-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. *Zeigler Coal Co. v. Kelley*, 112 F.3d 839, 842–43 (7th Cir. 1997); *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 131 (184). In addition, the judge is not required to accord greater weight to the most recent x-ray evidence of record, but rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.*, 2 B.L.R. 1-436 (1979).

Claimant asserts that he has provided evidence of complicated pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C. 20 CFR §§ 718.202; 718.304(a). I review the five chest x-ray films in the current record accordingly.

The first chest x-ray film dated July 9, 1980 was interpreted as positive ("2/3") by a dually-qualified radiologist and as unreadable by a similarly-qualified radiologist. I find that the results of this x-ray are inconclusive.

The March 27, 2001 film was interpreted as positive for pneumoconiosis by one dually-qualified radiologist ("3/2") and also as positive ("2/1") by a physician who is only a B-reader. It was interpreted as negative ("0/1") by a dually-qualified radiologist. The weight of the evidence establishes that this chest x-ray film is positive for pneumoconiosis.

The film dated May 16, 2001 was read as positive for complicated pneumoconiosis by a dually-qualified radiologist ("3/2;" type A opacities) and as positive ("1/0") for simple pneumoconiosis by a similarly-qualified radiologist. I find that this chest x-ray film supports a finding of simple pneumoconiosis only.

The film dated February 7, 2003 was read as positive for complicated pneumoconiosis by a dually-qualified radiologist ("3/2;" type A opacities) and as negative by a similarly-qualified radiologist. I find that this chest x-ray film is in equipoise.

Finally, the most recent film dated July 14, 2004, was read as positive for complicated pneumoconiosis by a dually-qualified radiologist ("3/2;" type A opacities) and as negative by a similarly-qualified radiologist. I find that this chest x-ray film is in equipoise.

I find that the chest x-ray evidence weighs in favor of a positive finding of simple pneumoconiosis. More of the physicians who reviewed the films as positive found simple pneumoconiosis, rather than complicated pneumoconiosis. Given that two films from 2001 were read as positive for pneumoconiosis, and that the rest of the films are all in equipoise, it appears that the chest x-ray evidence as a whole tips in favor of a positive finding of simple pneumoconiosis.

I further find that the CT scan evidence is inconclusive on the issue of whether or not Claimant has complicated pneumoconiosis. The radiologists who reviewed this evidence dispute whether the CT scans show a disease process such as tuberculosis, granulomatous disease, or

histoplasmosis, or the presence of complicated pneumoconiosis. Two highly qualified physicians, Dr. Wheeler and Dr. Scott, both interpreted the various CT scans as showing evidence of the former conditions, whereas Dr. Alexander found complicated pneumoconiosis. However, Dr. Alexander is the only radiologist of record to find complicated pneumoconiosis. I find that his opinion is less consistent with the record as a whole and that this detracts from his opinion about these scans. I am unable to conclude that the CT scans disclose the presence of complicated pneumoconiosis.

Biopsy or autopsy evidence § 718.202(a)(2).

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the record contains no such evidence.

Regulatory presumptions § 718.202(a)(3).

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires x-ray, biopsy or equivalent evidence of complicated pneumoconiosis, a condition that I have determined is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians opinions § 718.202(a)(4).

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in § 718.202(a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

In assessing the physician opinions, I first note that despite Dr. Pfister's status as treating physician, his report is not fully reasoned and, as such, is entitled to little weight. With respect to the remaining physicians, Drs. Ranavaya, Cohen and Zaldivar diagnosed simple pneumoconiosis. Dr. Branscomb did not make a definitive finding of pneumoconiosis, but suggested that if pneumoconiosis were present, it was of a simple, not complicated type. I find, therefore, that the physician opinion evidence of record supports a positive finding of pneumoconiosis.

In weighing all of the evidence together, I find that it establishes the presence of pneumoconiosis. The chest x-ray films, the physician opinion evidence, and Claimant's hospital records consistently support this conclusion. The CT scan evidence does not detract from this finding.

Based on the foregoing, Claimant has established that he has pneumoconiosis. In doing so, he has shown a change in condition pursuant to § 725.309(d).

B. Pneumoconiosis Arising Out of Coal Mine Employment

Based on Claimant's 45.93-year coal mine employment history, he is entitled to a rebuttable presumption that pneumoconiosis, if present, arose out of his coal mine employment. § 718.203(b). There is no evidence in the current or previous record that rebuts this presumption.

Based on the foregoing, I find that Claimant has established that his pneumoconiosis arose out of coal mine employment.

C. Total Respiratory Disability

In order for Claimant to prevail, he must establish that he is totally disabled due to a respiratory or pulmonary condition. Total disability is defined in § 718.204(b)(1) as follows:

> A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner (i) [f]rom performing his or her usual coal mine work; and (ii) [f]rom engaging in [other] gainful employment in a mine or mines.

§ 718.204(b)(1). Non-pulmonary and non-respiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a); *see also Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). Finally, § 718.204(a) also provides that:

> If, however, a non-pulmonary or non-respiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition shall be considered in determining whether the miner is or was totally disabled [under the Act].

§ 718.204(a).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. § 718.204(b)(2)(i–iv). A presumption of total disability is not established by a showing of evidence qualifying under a subsection of § 718.204(b)(2), but rather such evidence shall establish total disability in the absence of contrary evidence of greater

weight. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). There is no evidence of cor pulmonale with right-sided congestive heart failure in this case. Therefore, total disability analysis is based on pulmonary function studies, arterial blood gas studies, and physician opinions.

Pulmonary Function Studies at 20 C.F.R. § 718.204(b)(2)(i).

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, after accounting for sex, age, and height, produce a qualifying value for the FEV_1 test, and produce either a qualifying value for the FVC test or the MVV test, or produce a value of FEV_1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV_1, FVC, and the MVV tests are measured results less than or equal to values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718, 20 C.F.R. § 718.204(b)(2)(i). *Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n.5, 13 B.L.R. 2-259 (3d Cir. 1990). Assessment of pulmonary function study results is dependent on Claimant's height, which was listed most frequently as 66 inches. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983).

The pulmonary function studies in the current record did not produce qualifying values. Based on the foregoing, I find that this evidence does not support a finding of total disability.

Arterial Blood Gas Studies at 20 C.F.R. § 718.204(b)(2)(ii).

Pursuant to § 718.204(c), total disability can also be established by qualifying arterial blood gas studies. The arterial blood gas studies in the current did not produce qualifying values. Based on the foregoing, this evidence does not support a finding of total disability.

Physician Opinion Evidence at 20 C.F.R. § 718.204(b)(2)(iv).

Of the five physicians who gave opinions regarding total disability, only Dr. Cohen found that Claimant was totally disabled from a pulmonary standpoint. Dr. Pfister stated only that Claimant was "disabled." This is not equivalent to a finding of total disability and, as I have observed, Dr. Pfister's opinion is wholly unreasoned. The remaining physicians of record, Drs. Ranavaya, Zaldivar, and Branscomb, found that Claimant did not have a total respiratory disability. Dr. Zaldivar and Dr. Cohen are both Board-certified pulmonologists and as such are equally qualified. As there are two other physicians who concur with Dr. Zaldivar, however, I find that the physician opinion evidence does not support a finding of total respiratory disability.

In weighing all of the evidence together, the pulmonary function studies, the arterial blood gas studies, and the physician opinion evidence, I find that Claimant has not established that he has a total respiratory disability.

Based on the foregoing, Claimant has not established this element of entitlement.

D. Total Disability Due to Pneumoconiosis

Claimant bears the burden of proving that pneumoconiosis is a substantial contributor to a miner's total respiratory disability by a preponderance of the evidence. 20 C.F.R. § 718.204(c)(1). *See also Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986) (en banc). Sections 718.204(c)(1)(i) and (ii) provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1)(i), (ii). Disability due to pneumoconiosis may be established by a documented and reasoned medical report. § 718.204(c)(2).

Claimant is unable to show that he has a total respiratory disability and, therefore, this issue is moot.

Based on the newly submitted evidence, I find that Claimant has established that he has pneumoconiosis arising from his coal mine employment. In doing so, he has shown a material change in condition and the record must be reviewed de novo.

E. De Novo Review of the Record

In reviewing the record de novo, I find that the conclusion reached herein is unchanged. As with the current record, the previously submitted evidence tends to support a positive finding of pneumoconiosis, but does not support a finding of total disability.

In reviewing the record as a whole, I find that Claimant has not established that he has a total respiratory disability due to pneumoconiosis.

CONCLUSION

Although Claimant has established that he has pneumoconiosis arising out of coal mine employment, he is unable to show that he has a total respiratory disability.

Based on the foregoing, Claimant is not entitled to benefits under the Act.

ORDER

The claim of CHARLES W. HUDSON for benefits under the Act is hereby DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.